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Health Homes Serving Children in Foster Care Information on the NYS Child Welfare System and Defining the Collaborative Roles

Introductions and Today's Presenters

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Context and Objectives

- NYS Child Welfare framework
- Types of Foster Care placements and lengths of stay
- Health Care requirements for Foster Care children
- Health Home expansion information
- Defining the collaborative roles – Current roles and New functional roles of:
 - **Local Department of Social Services (LDSS) Case Manager**
 - **Voluntary Foster Care Agency (VFCA) Case Planner**
 - **Health Home (HH) Care Manager**
- What happens at Foster Care discharge



NYS Child Welfare Framework and Legal Authority

To protect children from abuse and maltreatment, NYS created a child protective system with the following:

1. Mandatory and voluntary reporting of suspected child abuse and maltreatment to the NYS Office of Children and Family Services (OCFS) State Central Register (SCR)
2. Local Departments of Social Services (LDSS) engage in child protective services investigations
3. When indicated, LDSS removal of a child and placement into custody by Family Court order
4. Legal Authority: the Family Court Act transfers the care and custody of children to the Commissioner of the LDSS through
 - Article 3 for Juvenile Delinquents (JD)
 - Article 7 Persons In Need of Supervision (PINS)
 - Article 10 (abuse/neglect)
 - 10-C (destitute child) 5, SSL 358-a (approval of a SSL 384 surrender), or SSL 384-b (deceased parents)



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New York State Child Welfare Operational Model: Supervised by OCFS and Operated by LDSS

- New York State is a state supervised-locally operated child welfare system: State supervised by OCFS and locally operated by LDSS. LDSS in NYS includes: 57 counties, New York City's Administration for Children's Services (the 5 Boroughs of NYC), and St. Regis Mohawk Tribe
- As of the Fall of 2015, LDSS contract with 92 Voluntary Foster Care Agencies across NYS for approximately 16,500 children (out of the approximately 19,000 in foster care)

***NOTE – Children in foster care in NYS are categorically eligible for Medicaid until the age of 21. Effective January 1, 2014, the Affordable Care Act extends Medicaid coverage through the age of 26 for youth who were in foster care at the age of 18 and in receipt of Medicaid**



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New York State Child Welfare Operational Model: Supervised by OCFS and Operated by LDSS

LDSS Direct Care population

- Direct Care Foster Care defined as children placed in foster homes licensed by the LDSS. Includes approximately 3,500 children across NYS that moved into Managed Care between April 1, 2013 – September 2013
- OCFS and DOH created NYS DOH Policy Paper that outlines the guidance for children in direct care foster care into Managed Care. OCFS held a series of conference calls with LDSS and Managed Care Organizations (MCOs) to review the contents of the NYS DOH Policy Paper in preparation for April 1, 2013 all children in direct care across NYS moving into Managed Care. Enrolling this population in Managed Care and sorting out the various needs of children, families, LDSS and Managed Care Plans is still a “work in progress”

LDSS Contracts with Voluntary Foster Care Agencies

- LDSS contracts with Voluntary Foster Care Agencies for the placement and services for children in foster care, which occurs in 80% of the cases in NYS.

Why are some children placed in Direct Care and others not?

It is a LDSS decision that is generally based upon the identified needs of the children



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Types of Foster Care Placements Provided by Voluntary Foster Care Agencies

- The general goal in foster care is to place the child in the least restrictive, most family-like placement appropriate to meet the needs of the child.
- **Foster Boarding Homes:** a certified foster boarding home is a home that is licensed by the Voluntary Foster Care Agency and receives a certificate to provide foster care services. The certificate limits the number of children to be placed in the home and states any restrictions on child characteristics. This may include specialized foster homes such as Therapeutic Foster Boarding homes.
- **Congregate Care:** Group foster care placements operated mostly by Voluntary Agencies Group Homes within the size limits:
 - Group Homes (less than 12 beds)
 - Group Residences (12-24 beds)
 - Institutions (aka Residential Treatment Centers) (25+ beds)



Length of Stay and Re-Admissions into Foster Care

- The average length of stay in foster care in New York State is 290 days, while in NYC it is 334 days
- Age is an important variable that impacts the length of stay
 - Children under the age of one at admission have the longest length of stay
 - Youth between the ages of 13 and 17 at admission have the shortest length of stay, the median duration is 257 days
- A significant percentage of children who exit the system re-enter it again, with more than half of 10 -13 year olds experiencing more than one placement during the time they are in foster care. The most common placement for 14–17 year olds is group homes and other types of congregate care.



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Health Care Requirements for Children in Foster Care

- Federal standards include Early and Periodic Screening, Diagnostic and Treatment (EPSDT) and Adoption and Safe Families Act (ASFA)
- NYS Regulations require that LDSS and voluntary agencies arrange and coordinate the health care; these standards include mandatory assessments and enhanced well child visits
- National standards of health care were developed for children in foster care by the American Academy of Pediatrics and the Child Welfare League of America
- Family courts will “court order” services for children and families, including medical evaluations and health care services for children
- More information can be found on Health Services for Children in Foster Care at the below link:
 - http://ocfs.ny.gov/main/sppd/health_services/



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Health and Behavioral Health Care Needs

- Children in the foster care system have higher rates of birth defects, developmental delay, and physical disability than children from similar socio-economic backgrounds
- There is a high prevalence of medical and developmental problems and use inpatient and outpatient mental health services at a rate 15 – 20 times higher than the general pediatric Medicaid population. The impact of the trauma these children experience is profound

Select Problems at Entry into Foster Care (Source: American Academy of Pediatrics)

Psychosocial Problems (with a high percentage having experienced childhood adversity and trauma)	100%
Chronic physical health condition	35-45%
Birth defect	15%
Mental health problem	40-95%
Significant dental condition	20%
Family problems	100%
Developmental Delay in child <5yrs	60%
Special ed./underachievement	45%

Tailoring NYS Health Home Model to Serve Children

- Health Homes designated to serve children will begin enrolling eligible children in October 2016.
- Children in foster care **may** also be eligible for Health Home Care Management. Foster care status does **NOT** make a child automatically eligible for Health Home Care Management.
- Under the Health Home model, when a child meets Health Home eligibility and appropriateness, the Voluntary Foster Care Agency (VFCA) serving this child would become the Health Home Care Management Agency.
 - The State is requiring that every Health Home contracts with at least one VFCA, but is recommended that the Health Homes contract with all VFCA's in their geographic area.
 - Health Homes and VFCAs should be reaching out to one another to initiate this contracting process and establish relationships.
 - Note when foster care children are enrolled in Managed Care their will also need to be alignment between the VFCA, the Health Home and the Plan



Tailoring NYS Health Home Model to Serve Children continued

- **In NYC:**
 - ACS, who has care and custody of children in foster care, places the children with Voluntary Foster Care Agencies (VFCA). The VFCA becomes the Health Home care management agency for Health Home eligible children/youth who meet all requirements to receive Health Home care management services.
 - The VFCA selected by ACS will enroll the child in the Health Home that the VFCA contracts with
- **In the Rest of State:**
 - The LDSS Commissioner, who has care and custody of the child in foster care will refer the child for Health Home services via the MAPP portal.
 - The LDSS will select the care management agency for Health Home eligible children/youth in foster care who meet all requirements to receive Health Home care management services.
- The LDSS Case Managers, VFCA Case Planners, and HH Care Managers will function as a team to develop mutual goals to obtain optimal outcomes



Who is eligible for Health Home Care Management?

- Medicaid (children in foster care are categorically eligible for Medicaid)
 - Fee for Service
 - Managed Care
- Health Home Eligibility Criteria
 - Does the child/youth meet Health Home eligibility criteria?
 - Does the child/youth meet Health Home appropriateness criteria?
 - Not every child in foster care that meets Health Home eligibility requirements will be appropriate for Health Home. Does the child need the comprehensive care management provided by the Health Home?



Health Home *Chronic Condition* Eligibility Criteria

- The individual **must** be enrolled in Medicaid
- Medicaid members eligible to be enroll in a Health Home **must** have:
 - Two or more chronic conditions (e.g., Substance Use Disorder, Asthma, Diabetes*) **OR**
 - One single qualifying chronic condition:
 - ✓ HIV/AIDS or
 - ✓ Serious Mental Illness (SMI) (Adults) or
 - ✓ Serious Emotional Disturbance (SED) or Complex Trauma (Children)

* See DOH Website for list of chronic conditions

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/09-23-2014_eligibility_criteria_hh_services.pdf

- Chronic Condition Criteria is NOT population specific (e.g., being in foster care, under 21, in juvenile justice etc. does not alone/automatically make a child eligible for Health Home)
- In addition, the Medicaid member **must** be appropriate for the intensive level of care management services provided by Health Home, i.e., satisfy appropriateness criteria



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Health Home Appropriateness Criteria

- ***Individuals must meet the Chronic Condition Criteria AND be Appropriate for Health Home Care Management***
- ***Appropriateness Criteria:*** Individuals meeting the Health Home eligibility criteria **must be appropriate for the intensive level of care management provided by Health Homes.** Assessing whether an individual is appropriate for Health Homes includes determining if the person is:
 - ✓ At risk for an adverse event (e.g., death, disability, inpatient or nursing home admission, mandated preventive services, or out of home placement)
 - ✓ Has inadequate social/family/housing support, or serious disruptions in family relationships;
 - ✓ Has inadequate connectivity with healthcare system;
 - ✓ Does not adhere to treatments or has difficulty managing medications;
 - ✓ Has recently been released from incarceration, placement, detention, or psychiatric hospitalization;
 - ✓ Has deficits in activities of daily living, learning or cognition issues,
 - ✓ Is concurrently eligible or enrolled, along with either their child or caregiver, in a Health Home

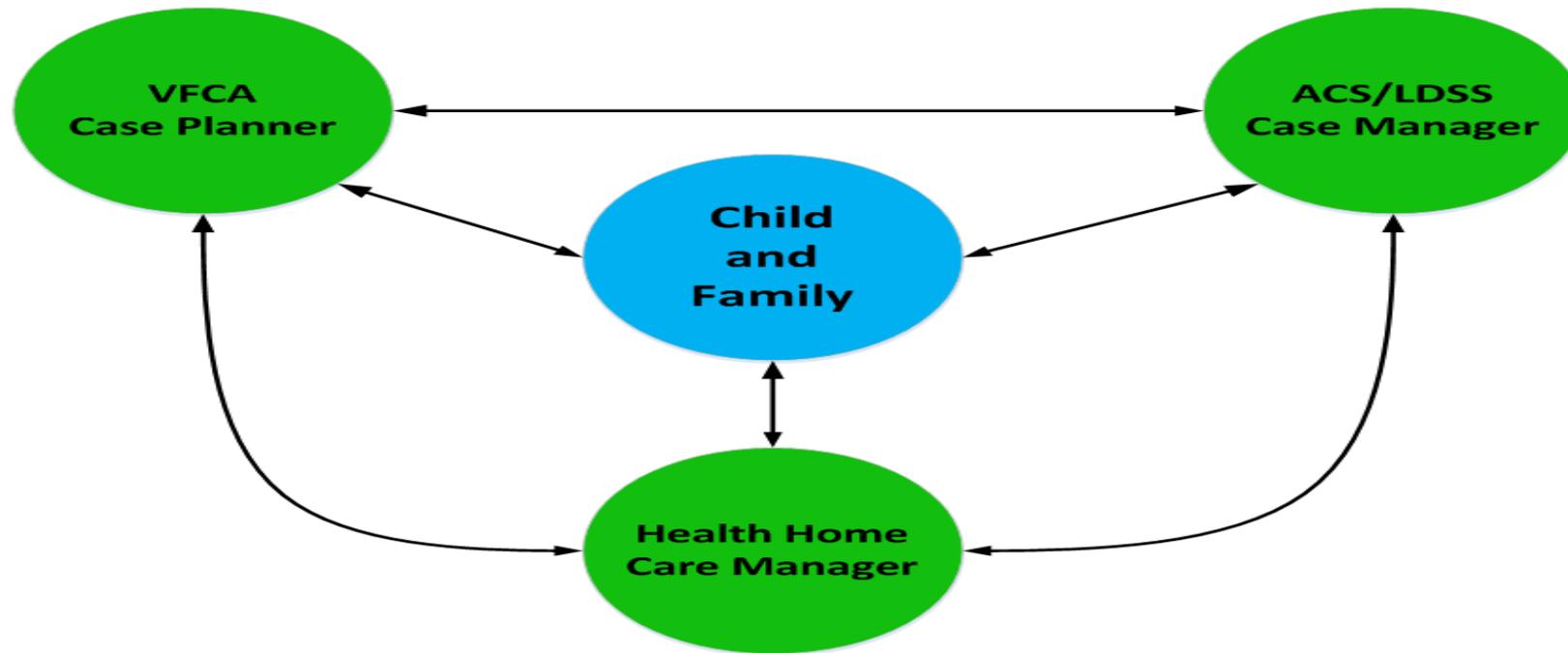
Defining the Collaborative Roles

- **LDSS Case Manager**
 - Current role
 - New role related to Health Homes
- **VFCA Case Planner**
 - Current role
 - New role related to Health Homes
- **Health Home Care Manager**



A New Team Approach for Serving Children and Families in Voluntary Foster Care Agencies

- All members of the multi-disciplinary team must work closely together throughout the child's stay in foster care.



Current Roles of the LDSS Case Manager

The LDSS Case Manager is responsible for the following key elements:

- The Adoption and Safe Families Act (ASFA) of 1997:
 - Promote permanency
 - Ensure safety and well-being for abused and neglected children
 - Accelerate permanent placements of children
- Concurrent Planning
- Placement of the child and authorizing the provision of services
- Medical consent for all related medical treatment and procedures
- Oversight of case, approving the Family Assessment and Service Plan (FASP) and working with the Family Court system
- Facilitate Medicaid enrollment
- Enrollment and Managed care plan selection, where applicable
- Adherence with applicable state and federal regulations related to health care services



LDSS Case Manager Continued

The Family Assessment and Service Plan includes the following:

- ♦ Family Update
- ♦ Safety Assessment
- ♦ Strengths, Needs and Risks of the Child and Parent/Caretaker
- ♦ Appropriateness of Placement
- ♦ Adjustment and Functioning
- ♦ Permanency Progress/Concurrent Planning
- ♦ Life Skills Assessment
- ♦ Family/Child Visiting Plan
- ♦ Foster Care Discharge
- ♦ Programmatic Eligibility
- ♦ Service Plan



LDSS Case Manager

Placement

Medicaid Enrollment

MCO

Oversight and Approval



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NEW Functional Roles of the LDSS Case Manager Related to Health Homes

New LDSS roles* include:

- Referring Health Home eligible/appropriate children/youth through the MAPP referral portal to the Health Home program
- Selecting the VFCA to provide Health Home Care Management
 - For more information on the MAPP referral process please see the April 29, 2015 and May 11, 2015 webinars on the DOH website.
 - https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/4_29_2015_children_webinar.pdf
 - https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hhsc_5_11_2015_webinar.pdf
- Collaborating with the HHCM and the VFCA Case Planner in the development, implementation and modification of the Health Home Plan of Care to assure it is consistent with the FASP.

* In NYC the LDSS Case Manager roles have been assigned to the VFCA Case Planner



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Roles of the VFCA Case Planner

The VFCA Case Planner has the primary responsibility for providing or coordinating and evaluating the provision of Child Welfare Services including:

- Completing the FASP.
- Referring the child in foster care and his/her family to providers of services and delineating the roles of the various service providers related to the child's permanency planning.
- Collaborating with all case workers assigned to the family's case so that a single FASP is developed for a child.



New Functional Roles of the VFCA Case Planner

These roles include:

- Collaborates with the HHCM and LDSS Case Manager (with the exception of NYC foster care children).
- Coordinates and facilitates the FASP team meetings with the HHCM.
- Collaborates with the HHCM on the development of the Health Home Plan of Care
 - The FASP will be supplemental information used to develop the comprehensive care plan prepared by the Health Home Care Manager
- VFCA Case Planner is an integral part of the multi-disciplinary team



Health Home Care Manager

Six Core Services of Health Home Care Management and how they relate to Serving Foster Care Children:

1. Comprehensive Care Management
2. Care Coordination and Health Promotion
3. Comprehensive Transitional Care
4. Patient and Family Support
5. Referral to Community and Social Support Services
6. Use of Health Information Technology (HIT) to Link Services

Detailed description of the activities to be performed to deliver the six core services can be found in the Health Home Application to Serve Children Part II at:

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_serving_children_app_part_ii.pdf



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Comprehensive Care Management

- The HHCM, in collaboration with the child's family and the multi-disciplinary team (which includes the child welfare team, the LDSS Case Manager and/or VFCA Case Planner) develops and executes the HH Plan of Care.
- The HH Plan of Care identifies all providers (the multi-disciplinary team) directly involved in the child's care (e.g., the primary care physician/nurse practitioner, specialist(s), behavioral health care provider(s), community, social and peer supports, education system).
- All parties should agree with the goals, interventions and timeframes contained in the Plan of Care.
- The HHCM is the single point of contact for creating, documenting, executing and updating the individualized child centered HH Plan of Care that integrates medical, behavioral health, rehabilitative, long term care, community and social services, family and peer supports, and the FASP.



Comprehensive Care Management Continued

- **The HHCM completes the Child and Adolescent Needs and Strengths-NY (CANS-NY).**
 - The CANS-NY is a decision making tool designed to serve as a guide to assist in developing a HH Plan of Care for children with behavioral needs, medical needs, developmental disabilities, and juvenile justice involvement.
 - The HHCM may also use other assessments and information obtained from the multi-disciplinary team to complete the Plan of Care.



Comprehensive Care Management Continued

- The HHCM will update the Plan of Care, including periodic reassessment of the child's individual needs and his/her progress in meeting goals.
- **The HH Plan of Care should include, facilitate, and be consistent with the FASP.**
- Ensures compliance with Health Home policies, standards and requirements:
 - Eligibility
 - Timeframes
 - Documentation
 - Provision of six core services



Care Coordination and Health Promotion

- Engages and retains Health Home enrollees in care; coordinates and arranges for services; supports adherence to treatment recommendations; monitors and evaluates children/youth's needs, including prevention, wellness, medical, specialist and behavioral health treatment, care transitions, and social and community services through the creation of a Plan of Care.
- The HHCM works with the multi-disciplinary team to discuss changes in the child's condition that may necessitate treatment and service changes.



Care Coordination and Health Promotion Continued

- Ensures the availability of priority appointments for Health Home enrollees for medical and behavioral health care services within their Health Home provider network to avoid unnecessary, inappropriate utilization of emergency room and inpatient hospital services.
- Ensures timely access to care.
- Work collaboratively with the LDSS Commissioner or designee to ensure care and treatment for the child in accordance with the LDSS expectations



Comprehensive Transitional Care

- **Provides timely access to follow-up care post discharge from hospital, emergency room or residential/rehabilitation setting.**

This includes:

- Receipt of a summary care record from the discharging entity;
- Medication reconciliation;
- Timely scheduled appointments with recommended outpatient providers;
- Verification with outpatient providers that the child/youth attended the appointment, as well as a plan to outreach and re-engage in care if the appointment was missed.



Comprehensive Transitional Care Continued

- Ensures all members of the multi-disciplinary team are aware of admission and/or discharge to/from an emergency room, inpatient, or residential/rehabilitation setting.
- Ensures coordinated, safe transitions in care for children who require transfers in their site of care.
- ***Ensures ongoing care and seamless transitional planning (i.e. Medicaid coverage, linkage with health care providers) and care management for children that are discharged from foster care and continue to meet Health Home eligibility criteria (in Medicaid and meet chronic conditions)***



Patient and Family Support

- Communicates and shares information with LDSS, VFCA and families/caregivers.
- Shares HH Plan of Care and options for accessing clinical and other information with caregivers.
- Utilizes peer supports, support groups and self-care programs to increase child/youth knowledge about his/her disease/behavioral health care needs, engagement and self-management capabilities to improve adherence to prescribed treatment.



Referral to Community and Social Support Services

- In collaboration with the LDSS Care Manger and the VFCA Case Planner, identifies available community-based resources and actively manages appropriate referrals, access, engagement, social supports, follow-up and coordination of services that respond to the child's needs and preferences and contribute to achieving the child's goals.

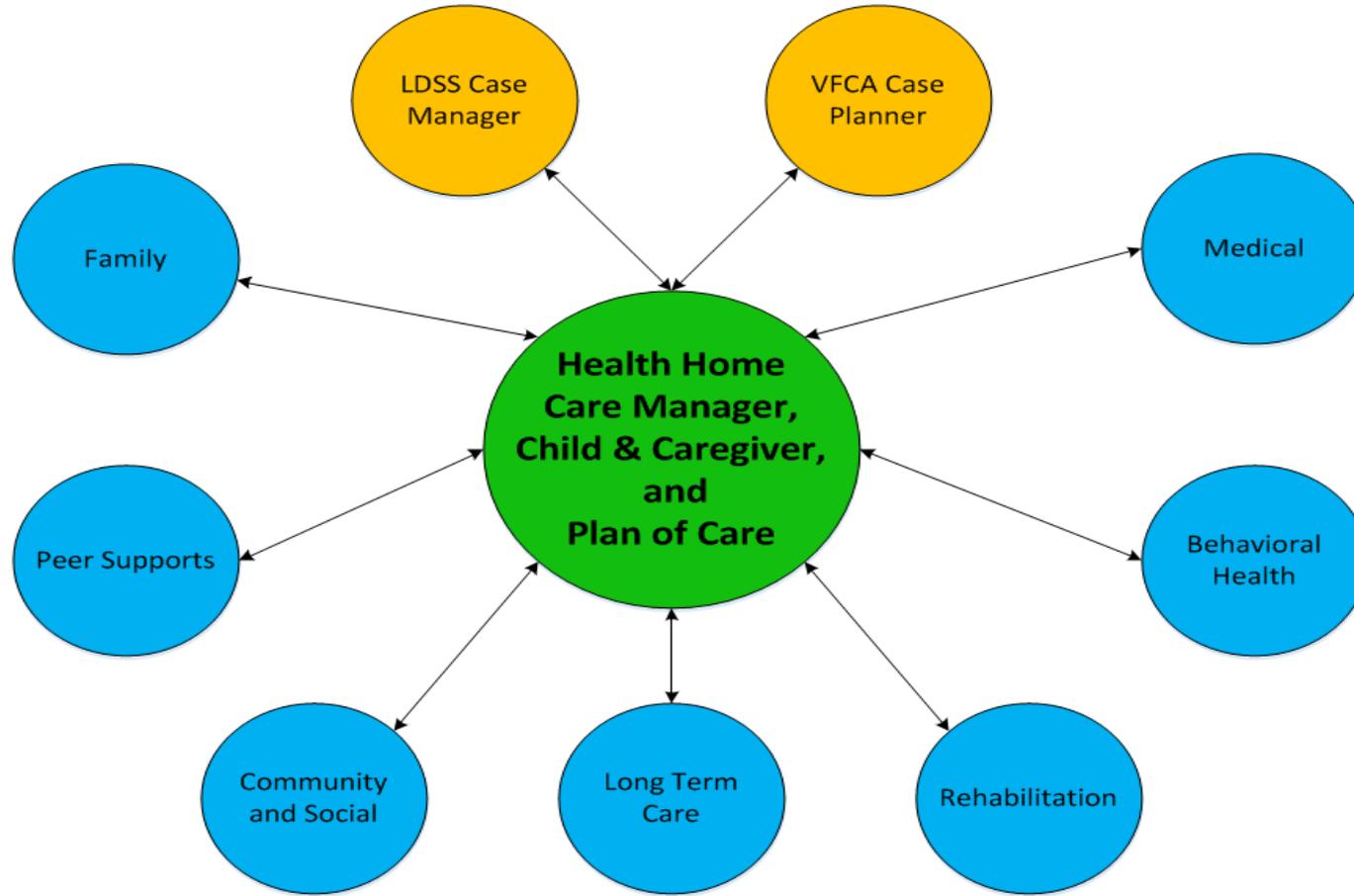


Use of Health Information Technology (HIT) to Link Services

- The HHCM inputs information into the Health Home's administrative system/care coordination software to allow the child's health information and HH Plan of Care to be accessible to the multi-disciplinary team, and also allowing for population management and identification of gaps in care. The HHCM documents follow up on tests, treatments, services, and referrals to be incorporated in the child's HH Plan of Care in the Health Home's administrative system/care coordination software.
- Inputs information in MAPP as required.
- The HHCM will have access to CONNECTIONS to view required information that may assist in developing the HH Plan of Care and shall input information in CONNECTIONS Progress Notes as needed.



Development of Health Home Plan of Care



Functional Roles of HHCM related to NYS Child Welfare Continued

- Provides all information about the child's health and welfare to the LDSS.
- Collaborates to ensure that safety, permanency and well-being are addressed within the provision of the six core services of Health Home Care Management, and that services are not duplicated.

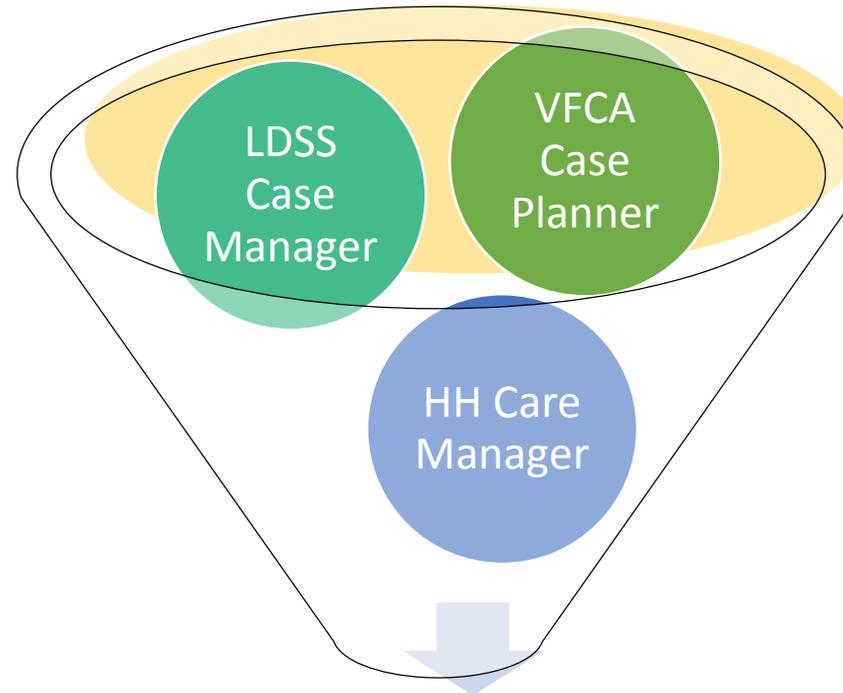


What Happens at Discharge from Foster Care?

- The primary goals of the foster care system are to achieve safety, permanency, and well-being for the child and family.
- At final discharge, the roles of the LDSS Case Manager and the VFCA Case Planner end.
- A child who remains eligible and appropriate for Health Home Care Management can continue to receive services from the HHCM if they choose to do so.
- The provision of continued Health Home Care Management should be reflected in the foster care discharge plans created by the VFCA Case Planner and LDSS Case Manager as well as the HH Plan of Care. All parties should work together to ensure this transition is as smooth as possible.



Bringing it together...



**HH Plan of Care + FASP =
Child's Safety, Permanency and
Well Being**

What Should your Health Homes and LDSS do Next?

- Reach out and collaborate with one another – Get to know each other!
- Health Homes work to ensure your network includes VFCA (part of contingent designation)
 - Reach out to the VFCAs in your areas and established Business Associate Agreements (BAAs) if you have not already done so
- Reach out to your Local Department of Social Services to make them aware of your Health Home
 - The LDSS can share their list of contracted VFCAs
 - State will provide a comprehensive list of HH and VFCA linkages later this Summer
 - The LDSS can share specific statistics surrounding their county's foster care children as well as other services provided to children in their county



Health Homes Serving Children List of Acronyms

- ACS: NYC Administration of Children Services
- AI: AIDS Institute
- ALP: Assisted Living Program
- ASA: Administrative Service Agreement
- BAA: Business Associate Agreement
- BHO: Behavioral Health Organization
- CAH: Care at Home
- CBO: Community Based Organizations
- CMA: Care Management Agency
- DEAA: Data Exchange Agreement Application
- EI: Early Intervention
- FFS: Fee For Service
- HCBS: Home and Community Based Services
- HCS: Health Commerce System
- HH: Health Home
- HHSC: Health Home Serving Children
- HIT: Health Information Technology
- LDSS: Local Department of Social Services
- LGU: Local Government Unit
- MAPP: Medicaid Analytics Performance Portal (Health Home Tracking System)



Health Homes Serving Children List of Acronyms

- MCO/MCP: Managed Care Organization / Managed Care Plan
- MRT: Medicaid Redesign Team
- MMIS #: Medicaid Management Information Systems
- NPI #: National Provider Identifier
- OASAS: Office of Alcoholism and Substance Abuse Services
- OCFS: Office of Children and Family Services
- OMH: Office of Mental Health
- OMH-TCM: Office of Mental Health Targeted Case Management
- SED: Serious Emotional Disturbance
- SMI: Serious Mental Illness
- SPA: State Plan Amendment
- SPOA: Single Point of Access
- SPOC: Single Point of Contact
- TCM: Targeted Case Management
- UAS: Universal Assessment System
- VFCA: Voluntary Foster Care Agency

